Stanford Children's Health

New Patient

Patient label

Patient Name: _____ Date of Birth:_____ Age: _____

Parent name(s) and occupation(s):_____

Former pediatrician(s): _____

PAMF/Sutter UCSF Kaiser Other:

Other providers caring for your child: _____

Pharmacy and address: _____

Preferred lab: Stanford LabCorp Quest Other:

Birth and Developmental History *(if 3 years old or younger)*

Location:_____ Birthweight:_____ Vaginal / C-Section

Was the mother ill during pregnancy?	No	**YES**	Did your child have any trouble starting to breathe?	No	**YES**
Was the delivery on time?	Yes	**NO**	Did your baby have problems in the nursery or stay in the hospital for longer than planned?	No	**YES**

When did your child sit alone? **Walk without assistance?** **Say words?**

Past Medical History

Allergy	Reaction

Current medications, vitamins, fluoride or other nutritional supplements:

Past serious illnesses or injuries	Past surgeries	Past hospitalizations

Has your child had…

Eczema/Atopic dermatitis	Pneumonia	Seizure
Strep throat/Scarlet fever	Chickenpox (varicella)	Sinus problems
Wheezing/Asthma	Urine / kidney / bladder infection	Concussion
Ear infections (if so, how many?)	Vision issue	Hearing issue
Other:		

Immunization History

Is your child is up to date on immunizations?	Yes	**NO**
Has your child experienced a serious or unusual reaction to a vaccination?	No	**YES**
Did your child received the BCG vaccine for tuberculosis?	No	**YES**
Has your child has a positive tuberculosis test in the past?	No	**YES**

Social History

Who lives at home?	Where does your child spend most of the day (daycare, preschool, etc)?	Any family issues you'd like us to know about?

Family History

Relationship	Relevant medical conditions

Do any of these conditions run in the family (parents, grandparents, aunts, uncles, siblings)? **If so, please describe above**

Heart attack	Diabetes	Kidney disease
Angina	Cancer	Thyroid disease
High blood pressure	Skin cancer	Asthma
Bleeding or clotting disorder	Hepatitis	Eczema/Atopic dermatitis
Stroke	Immunodeficiency	Food allergy
High cholesterol	Tuberculosis or positive skin test	Autoimmune / Rheumatologic
Epilepsy / Seizures	Menstrual issues	Substance abuse / addiction
Developmental delay	Anemia	
Migraines	Depression or anxiety	
Vision issues	Eating disorder	
Deafness or hearing loss	Other:	

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